AMENDMENT NUMBER 1
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
AND
DORAL DENTAL OF TENNESSEE, LLC

This Contract, by and between the State of Tennessee, Department of Finance and Administration, Bureau of TENNCARE, hereinafter referred to as "TENNCARE" and Doral Dental of Tennessee, LLC, hereinafter referred to as the "CONTRACTOR", is hereby amended as follows:

1. Delete A.1.1 in its entirety and replace with the following:

A.1.1. Services. The Contractor will manage the program in a manner that assures an adequate network of qualified dental providers who render high quality, medically necessary, cost effective dental care. Furthermore, the Contractor will exercise every available means through this contract, provider agreement, office reference manual or Doral's policies and procedures to ensure that the program is managed in this manner.

2. Delete A.1.2.1. through A.1.2.4 in their entirety and replace with the following:

A.1.2.1. Preventive, diagnostic and treatment services for enrollees under age 21, in accordance with Attachment I for eligible individuals. Any limitations described in this Agreement, including Attachment I, shall be exceeded to the extent that it is necessary in accordance with EPSDT requirements. At any time, by amendment to this contract, TennCare may alter the covered benefits for the TennCare Standard members under 21.

A.1.2.2. Orthodontics. Orthodontics limited to individuals under 21 except when an orthodontic treatment plan is approved prior to the enrollee attaining 20 ½ years of age, and treatment is initiated prior to the recipient attaining 21 years of age, or when orthodontic treatment is the result of facial emiatrophy or congenital birth defects (if enrollee was covered by TennCare at birth). These services shall be provided in accordance with Attachment I for eligible enrollees.

A.1.2.3. Emergency Dental Benefits. Effective October 1, 2002, covered services for TennCare Medicaid and TennCare Standard Enrollees age 21 or older are limited to cases of accidental injury to or neoplasms of the oral cavity, life threatening infections that include, but are not limited to, individuals with severely compromised immune systems, organ donor recipients, or individuals with or scheduled to receive a prosthetic heart valve(s), accidental injury to natural teeth including their replacement (limited to the cost of bridgework of the replacement of teeth injured in an accident unless teeth implants are medically necessary) and the removal of impacted wisdom teeth. (The adult dental "accident" must be caused by some external force, like a car accident, not by some normal act of mastication, or grinding of teeth while sleeping, or any other naturally occurring circumstance and must have occurred during a period of TennCare eligibility and within twelve (12) months from the date service is requested.) These services are for all TennCare enrollees on and after October 1, 2002.

A.1.2.4. Optional Benefit Package. The CONTRACTOR shall develop a preventive and restorative dental benefit package which may, if directed by TennCare, be offered to TennCare Standard children under 21 years of age. This optional benefit package will be offered in consideration for a premium to be paid by said children (or their family or legal guardian) directly to the CONTRACTOR. The CONTRACTOR shall obtain written TENNCARE approval prior to implementation of the Optional Benefit Package. TENNCARE approval shall not be unreasonably withheld. The CONTRACTOR shall be responsible for billing and collection of premiums. The CONTRACTOR shall be responsible for securing an appropriately licensed underwriter to administer said benefit package at no expense to TENNCARE. Prior to entering an agreement with an underwriter, the CONTRACTOR shall submit a proposal to TENNCARE for review and approval. The rates for the premiums

assigned to the benefit package shall be included in this submission for review and approval by TENNCARE and the Department of Commerce and Insurance, TennCare Division. The CONTRACTOR shall not charge rates in excess of those approved by TENNCARE during the term of this Agreement. TENNCARE's approval of the CONTRACTOR's proposal may be conditional based on the CONTRACTOR's acceptance of specified Terms and Conditions setting out minimum requirements regarding the administration of the Optional Benefit Package.

3. Delete A.1.3 in its entirety and replace with the following:

A.1.3. Enrollee Cost Share Responsibilities. The CONTRACTOR and all providers and subcontractors shall not require any cost sharing responsibilities for TennCare covered services except to the extent that cost sharing responsibilities are required for those services by TENNCARE in accordance with TennCare rules and regulations or TENNCARE approved policies and procedures for TennCare Standard enrollees, nor may the CONTRACTOR and all providers and subcontractors charge enrollees for missed appointments. Enrollees may not be held liable for payments in the event of the CONTRACTOR's insolvency. Enrollees may not be held liable for payments in the event the State does not pay the CONTRACTOR, or the CONTRACTOR does not pay the provider. Subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the entity provided the services directly (i.e. no balance billing by providers.

Cost sharing responsibilities shall apply to services other than the preventive services described in Section A.1.2.1 and Attachments I and II of this Agreement and as specified in the table below. Co-payments shall be applied on a sliding scale according to the enrollee's income. The maximum out-of-pocket expenses an enrollee may incur as the result of cost sharing responsibilities shall also be limited according to the enrollee's income. The procedure code listing for preventive services is as follows:

Preventive Dental Services for Children Under 21 Years of Age

D1110	Prophylaxis (when billed for children over age 12 and under age 21)
D1120	Prophylaxis
D1201	Topical Application of Fluoride (Prophylaxis included) - child
D1203	Topical Application of Fluoride (Prophylaxis not included) - child
D1310	Nutritional Counseling for Control of Dental Disease
D1320	Tobacco Counseling for the Control and Prevention of Oral Disease
D1330	Oral Hygiene Instructions
D1351	Sealant per Tooth

The current sliding scale schedule to be used in determining applicable cost sharing responsibilities and out-of-pocket expenses for TennCare enrollees is described in the chart below. These cost share responsibilities do not apply to the Optional Benefit Package that is described in Section A.1.2.4 of this Agreement.

Co-Pay	**0 to 100% of Poverty**	**101-199% of Poverty**	**200% and Above Poverty**
Dental visits	0	$15 per visit	$25 per visit
Annual out-of-pocket maximum (includes all TennCare covered copay services)	N/A	$1,000 for individuals; $2,000 for families	$2,000 for individuals; $4,000 for families

The CONTRACTOR shall track and report to TENNCARE the amount of enrollee cost-sharing liabilities on a quarterly basis in a form and format to be specified by TENNCARE. TENNCARE shall aggregate cost-sharing information submitted by TennCare DBM, MCOs, BHOs and the

PBM to identify enrollees that have met or exceeded their annual out-of-pocket expenditure maximum. The CONTRACTOR agrees to coordinate reimbursement to enrollees, either directly or through its network providers, that have exceeded the applicable out-of-pocket maximum, upon receipt of notification by TENNCARE. Should the CONTRACTOR elect to reimburse enrollees through its network providers, the CONTRACTOR shall conduct an audit of the providers that have been reimbursed in order to assure that enrollees received appropriate credit and/or reimbursement and are held harmless for amounts that exceed their out-of-pocket maximum.

The CONTRACTOR shall be expressly prohibited from waiving or using any alternative cost sharing schedules, unless required by TENNCARE. Further, the CONTRACTOR shall not discourage enrollees from paying applicable co-payment obligations.

If, and at such time that TENNCARE amends the cost sharing rules, the rules shall automatically be incorporated into this Agreement and become binding on the DBM, and the DBM's providers.

The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor) plus any applicable amount of cost sharing responsibilities due from the enrollee as payment in full for the service. Should a provider, or a collection agency acting on the provider's behalf, bill an enrollee for amounts other than the applicable amount of cost sharing responsibilities due from the enrollee, once a CONTRACTOR becomes aware the CONTRACTOR shall notify the provider and demand that the provider and/or collection agency cease such action against the enrollee immediately. After notification by the CONTRACTOR, if a provider continues to bill an enrollee, the CONTRACTOR shall refer the provider to the TBI.

Providers or collection agencies acting on the provider's behalf may not bill enrollees for amounts other than applicable cost sharing responsibilities for TennCare covered services except as permitted by TennCare rule 1200-13-12-.08 and as described below. Providers may seek payment from an enrollee in the following situations:

1. if the services are not covered by TennCare and the provider informed the enrollee the services were not covered prior to providing the service. The provider is required to inform the enrollee of the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgment in writing prior to rendering the service. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills an MCO for the service that has been provided, the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee; or

2. if the enrollee's TennCare eligibility is pending at the time services are provided and if the provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills an MCO for the service the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee; or

3. if the enrollee's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable cost share amounts must be refunded when a claim is submitted to an MCO if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. (The monies collected shall be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim); or

4. the enrollee requests services that are non-TennCare covered services provided at the option of the CONTRACTOR in accordance with the terms of this Agreement.

4. Delete A.2.3 in its entirety and replace with the following:

A.2.3. Failure to Comply with Marketing and Enrollee Material Requirements. All services listed in Attachment IV must be provided as described and the materials must adhere to the

requirements as described and must not mislead, confuse, or defraud the recipients or the State Agency.. Failure to comply with the marketing and communication limitations contained in this Agreement, including but not limited to the use of unapproved and/or disapproved marketing and communication material, may result in the imposition by TENNCARE of one or more of the following sanctions which shall remain in effect until such time as the deficiency is corrected:

5. Delete A.4.1. in its entirety and replace with the following:

A.4.1 Access to Care. The CONTRACTOR shall maintain a network of dental providers with a sufficient number of providers who accept new TENNCARE enrollees within each geographical location in the state so that appointment waiting times do not exceed 3 weeks for regular appoints and 48 hours for urgent care. The Contractor must consider the following:

a. The anticipated Medicaid enrollment
b. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the DBM
c. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services
d. The numbers of network providers who are not accepting new Medicaid patients
e. The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.

The CONTRACTOR must ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. Services must be available 24 hours a day, 7 days a week, when medically necessary.

6. Add the following to Section A.4.:

A.4.5. Out of Network Providers. If the CONTRACTOR's network is unable to provide necessary medical services covered under the contract to a particular enrollee, the CONTRACTOR must adequately and timely cover these services out of network for the enrollee, for as long as the CONTRACTOR is unable to provide them. Out of network providers must coordinate with the CONTRACTOR with respect to payment. The CONTRACTOR must ensure that cost to the enrollee is no greater than in would be if the services were furnished within the network.

A.4.6 The CONTRACTOR must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

7. Delete Section A.5 in its entirety and replace with the following:

A.5. PROVIDER NETWORK REQUIREMENTS

A.5.1 The CONTRACTOR is encouraged to contract for the provision of services with Federally Qualified Health Clinics (FQHCs), FQHC look-alikes and metropolitan or county Health Departments and may, at the discretion of TENNCARE, be required to secure such contracts. In addition, where FQHCs with the capacity to deliver dental services are not utilized, the CONTRACTOR must demonstrate that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected needs in a service area without contracting with FQHCs.

If the CONTRACTOR utilizes FQHCs for services, the CONTRACTOR is required to address cost issues related to the scope of services provided by FQHCs and shall reimburse FQHCs on a cost related basis.

A.5.2 The CONTRACTOR must submit documentation assuring the adequate capacity and

services as specified by the State , and specifically as follows, but no less frequently than:

a. At the time the CONTRACTOR enters into a contract with the State.
b. At any time there has been a significant change (as defined by the State) in the CONTRACTOR's operations that would affect adequate capacity and services, including –
   1. changes in services, benefits, geographic service area or payments, or;
   2. enrollment of a new population in the DBM.

8. Delete A.7.4 in its entirety and replace with the following:

A.7.4. Referral Requirements. A patient must be referred by a general dentist or pediatric dentist to a dental specialist (e.g., oral surgeon, endodontist, orthodontist) for the initial visit for services requiring specialized expertise. Subsequent visits to the same specialist in a course of treatment do not require separate referrals. The CONTRACTOR must provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the enrollee to obtain one outside the network, at no cost to the enrollee. Additionally, The CONTRACTOR must have a mechanism in place to allow special needs enrollees and enrollees determined to require an ongoing course of treatment direct access to specialists as appropriate.

9. Add the following to A.8.3.1:

- results of any identification and assessment of any enrollee with special health care needs (as defined by the State) so that those activities need not be duplicated

- mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

10. Delete A.8.3.2.4 in its entirety and replace with the following:

A.8.3.2.4. Emergencies: Prior authorization shall not be required for emergency services prior to stabilization. The definition of emergency dental benefits covered under the scope of this agreement is found at Section A.1.2.3 and Attachment I Section II. Services provided in accordance with the following requirements that are outside of the scope of this agreement shall be considered an MCO responsibility. Coordination activities between the CONTRACTOR and the MCOs are outlined in Section A-8 of this agreement.

A.8.3.2.4 (a) CONTRACTOR may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary crae provider, MCO, or applicable state entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.

A.8.3.2.4 (b) An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

A.8.3.2.4 (c.) The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment.

A.8.3.2.4 (d) Post stabilization services are covered and paid for in accordance with provisions set forth in 42 CFR 422.113 (c). The MCO is financially

responsible for post-stabilization services obtained within or outside the managed care organization that are pre-approved by a plan provider or other MCO representative.

A.8.3.2.4 (e) The MCO is financially responsible for post-stabilizaiton care services obtained within or outside the MCO organization that are not pre-approved by a plan provider or other MCO organization representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MCO organization for pre-approval of further post-stabilization care services.

A.8.3.2.4. (f) The MCO is financially responsible for post-stabilization care services obtained within or outside the MCO organization that are not pre-approved by a plan provider or other MCO organization representative, but administered to maintain, improve or resolve the enrollee's stabilized condition if:

- The MCO does not respond to a request for pre-approval with 1 hour
- The MCO cannot be contacted; or
- The MCO representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 422.133©(3) is met.

A.8.3.2.4 (g) The MOC must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MCO organization..

A.8.3.2.4. (h) the MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

- A plan physician with privileges at the treating hospital assumes responsibility for the enrollee care;
- A plan physician assumed responsibility for the enrollee's care through transfer;
- An MCO representative and the treating physician reach an agreement concerning the enrollee's care; or
- The enrollee is discharged.

11. Delete A.10.1. in its entirety and replace with the following:

A.10.1. The Contractor shall have a program for recruiting dentists to join its provider network in areas of the State where there are deficiencies in the dental provider network.

12. Delete A.10.2.b. in its entirety and replace with the following:

A.10.2.b. Other Provider Termination: If a provider ceases participation in the DBM, the CONTRACTOR shall make a good faith effort to give a written notice of termination of a contracted provider within 15 days after receipt or issuance of termination notice to each enrollee who received his/her primary care from or was seen on a regular basis by the terminated provider.

13. Add the following language to Section A.11.5:

A.11.5.rr. Contracts must comply with requirements set forth in the BBA 1997 in 422.208 and 422.210 as it applies to physician incentive plans.

A.11.5.ss. The CONTRACTOR shall have in place written policies and procedures for the selection and/or retention of providers and policies and procedures must not discriminate against particular provider that service high risk populations or specialize in conditions that require costly treatment.

A.11.5.tt. The CONTRACTOR shall not discriminate for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. The CONTRACTOR's ability to credential providers as well as maintain a separate network and not include any willing provide is not considered discrimination.

A.11.5.uu. If the CONTRACTOR declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

14. Add the following to Section A.11.

A.11.6. Section A.11 shall not be construed to:

A.11.6.a. Require the CONTRACTOR to contract with providers beyond the number necessary to meet the needs of the enrollees.

A.11.6.b. Preclude the CONTRACTOR from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

Preclude the CONTRACTOR from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to enrollees

15. Delete A.12.1 in its entirety and replace with the following:

A.12.1. Legal Responsibility. The CONTRACTOR shall be responsible for the administration and management of all aspects of this Agreement and the health plan covered thereunder. If the CONTRACTOR elects to utilize a subcontractor, the CONTRACTOR shall assure that the subcontractor shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the subcontractor for purposes of this Agreement, without approval of the CONTRACTOR. No subcontract, provider agreement or other delegation of responsibility terminates or reduces the legal responsibility of the CONTRACTOR to TENNCARE to assure that all activities under this Agreement are carried out.
Subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the CONTRACTOR provided the services directly (i.e. no balance billing by providers).
CONTRACTOR must ensure that it evaluates each prospective subcontractor's ability to perform the activities to be delegated and must specify in a written agreement with the subcontractor the activities and report responsibilities delegated to the subcontractor. CONTRACTOR must provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. The CONTRACTOR's written agreement with the subcontractor must address the methodology for identifying deficiencies and providing corrective action plans.

16. Delete A.12.8 Notice of Approval in its entirety and renumber as follows:

A.12.9. Notice of Approval. Approval of subcontracts shall not be considered granted unless TENNCARE issues its approval in writing.

17. Add the following to Section A.:

A.12.10. Subcontract Relationship and Delegation: If the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall assure that the subcontracting relationship and subcontracting document(s) comply with the requirements of the Balanced Budget

Act of 1997, including but not limited to, compliance with the applicable provisions of 42CFR 438.230(b) and 42 CFR 434.6 as described below:

A.12.10.a. The CONTRACTOR shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.

A.12.10.b. The CONTRACTOR shall require that the agreement be in writing and specifies the activities and report responsibilities delegated to the subcontractor, and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

A.12.10.c. The CONTRACTOR shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review consistent with industry standards or State MCO laws and regulations.

A.12.10.d. The CONTRACTOR shall identify deficiencies or areas for improvement and the CONTRACTOR and the subcontractor shall take corrective action as necessary.

18. Add the following to Section A.15.2.:

vi. is no more restrictive than the State Medicaid program and

vii. addresses the extent to which the CONTRACTOR is responsible for covering services related to the following:

- The prevention, diagnosis and treatment of health impairments.
- The ability to achieve age-appropriate growth and development
- The ability to attain, maintain, or regain functional capacity

19. Delete A.16.1. in its entirety and replace with the following:

A.16.1. EPSDT Dental Services. The Contractor shall require Dental Providers to follow practice guidelines for preventive health services identified by TennCare including early periodic screening, diagnosis and treatment services (EPSDT) as specified in Attachment II. EPSDT services shall be provided to all TennCare enrollees under the age of twenty-one (21). EPSDT includes timely provision of exams, cleaning, fluoride treatment, sealants and referral for treatment of Child Members. Performance objectives have been established for providing EPSDT services. The Contractor will be evaluated on those performance objectives using the annual HCFA 416 report which measures the following: any dental service provided using ADA CDT3 codes 100-9999; preventive dental services provided using ADA CDT3 codes 1000-1999 and dental treatment services provided using ADA CDT3 codes 2000-9999.

20. Delete the first paragraph of A.17 in its entirety and replace with the following:

All enrollees shall have the right to file appeals regarding adverse actions taken by the CONTRACTOR. For purposes of this requirement, appeal shall mean an enrollee's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness, or availability of such benefits. The CONTRACTOR must notify the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing. Complaint shall mean an enrollee's right to contest any other action taken by the CONTRACTOR or service provider other than those that meet the definition of an adverse action. The CONTRACTOR shall provide readable materials reviewed and approved by TENNCARE, informing enrollees of their complaint and appeal rights. The CONTRACTOR has internal complaint and appeal procedures in accordance with TENNCARE rule 1200-13-12-.11 or any applicable TENNCARE rules, subsequent amendments, or subsequent Court Orders governing the appeals process.

21. Delete A.17.1.g. in its entirety and replace with the following:

A.17.1.g. All appellants shall have the right to reasonable assistance by the CONTRACTOR during the appeal process and must be informed of the rules that govern representation;

22. Delete A.18.3 in its entirety and replace with the following:

A.18.3 Peer Review Committee. The CONTRACTOR shall establish a Provider Peer Review Committee which shall meet regularly (no less than quarterly) to review the processes, outcomes, and appropriateness of dental care provided to enrollees. CONRACTOR will submit the names of proposed members to TennCare within sixty (60) days after the execution date of this Agreement. The CONTRACTOR'S Dental Director shall be the committee chairperson. The Committee shall include at least five (5) Participating Dental Providers who file at least twenty-five (25) TennCare claims per year. This requirement will be waived for the first six (6) months of the contract period if the CONTRACTOR can prove an equivalent mechanism for provider peer review during that period.

a. The Committee shall review and recommend to the Contractor and TennCare appropriate remedial action for any Participating Dental Provider who has provided poor quality of care.
b. The Committee shall coordinate with TennCare's Office of Quality Assurance regarding imposition of any sanctions against a Participating Dental Provider who has provided poor quality of care, including termination.
c. The Committee shall coordinate with TennCare in regard to issues involving fraud or abuse by any Participating Dental Provider as specified in Section A.24.
d. The Committee shall review and recommend appropriate action on appeals or inquiries provided by Members, Participating Dental Providers, TennCare or other persons regarding quality of care, access or other issues related to TennCare's Dental Program.

23. Delete A.18.5 in its entirety and replace with the following:

A.18.5. Credentialing. CONTRACTOR is responsible for ensuring that dentists and other oral health professionals, who are under contract to the organization, are qualified to perform their duties. CONTRACTOR is responsible for provider selection policies and procedures that cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. CONTRACTOR is responsible for primary credentialing of providers by validating, at a minimum, that the provider's license number is current, obtaining DEA certificate if applicable, obtaining evidence of malpractice insurance, obtaining a professional liability claims history, performing an NPDB or State Board query, researching sanctions against state licensure as well as Medicare/Medicaid sanctions. If there are additional requirements within the TennCare credentialing process that are outside the scope of existing contracts, those additional requirements would have to be satisfied at the CONTRACTOR'S next scheduled re-credentialing of the provider or when a new provider is added.

24. Delete A.20.2.a. in its entirety and replace with the following:

A.20.2.a. No enrollee shall be disenrolled from a health plan for any of the following reasons: Adverse changes in the enrollee's health; Pre-existing medical conditions; High cost medical bills, a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the plan seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees),; or Failure or refusal to pay applicable cost-sharing fees, except when TENNCARE has approved such disenrollment.

25. Delete A.23. in its entirety and replace with the following:

A.23 FINANCIAL REQUIREMENTS

If during the life of this Agreement TENNCARE directs the CONTRACTOR to operate as a risk-bearing entity for dental services, the CONTRACTOR shall establish and maintain all financial reserves required by the Tennessee Department of Commerce and Insurance of HMOs, Third Party Administrator or Prepaid Limited Health Services Organizations licensed by the State of Tennessee, including, but not limited to, the reserves required by Tennessee Code Annotated, Section 56-32-212 as amended or Section 56-51-136 as amended. The CONTRACTOR shall demonstrate evidence of its compliance with this provision to the Tennessee Department of Commerce and Insurance, TENNCARE Division, in the financial reports filed with that Department by the CONTRACTOR. The CONTRACTOR must notify the State of any person or corporation that has 5% or more ownership or controlling interest in the entity and such person or corporation must submit financial statements. The CONTRACTOR, unless a Federally Qualified HMO, must provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the debts if the entity becomes insolvent.

26. Add the following to A.24.2.:

A.24.2.k. Report the number of complaints of fraud and abuse made to State that warrant preliminary investigation. For each which warrants investigation, supply the

- Name, ID number
- Source of complaint
- Type of provider
- Nature of complaint
- Approximate dollars involved
- Legal and administrative disposition of the case

27. Delete A.25.2 in its entirety and replace with the following:

A.25.2 The following performance indicators related to EPSDT have been identified for on-going monitoring. The CONTRACTOR's failure to meet these benchmarks shall result in the CONTRACTOR being required to implement a corrective action plan as described in Section A.18.

Performance Indicator	Data Sources	Measure	Target	Benchmark
EPSDT	Encounter data; TENNCARE enrollment data	The percentage of children who received a periodic screen as defined by the HCFA/CMS 416 Report	100% screening	10 Percentage point increase over latest screening percentage in HCFA 416 report.

Performance Indicator	Data Sources	Measure	Target	Benchmark
School-Based Screenings	Encounter data; DOH data on school-based activity; TENNCARE enrollment data	Percentage of TENNCARE eligible children in need of dental services, identified through the Public Health Department's School-Based Screening Initiative, able to obtain care as specified in Section A.4 & A.15.8	100% of children receive screening within access and availability standards	90% of children receive screening within access and availability standards

Performance Guarantees

Performance Area	Data Sources	Definition	Guarantee	Penalty

Performance Area	Data Sources	Definition	Guarantee	Penalty
Network Management	Monthly claims activity by provider Monthly Utilization Review Process	Appropriate level of services delivered as measured statistically across dentists with like credentials	Dental providers are expected to provide services in accordance with policies and procedures outlined in the Office Reference Manual and appropriate for the needs of the member. Provider over utilization/ underutilization 3 standard deviations from the mean will result in provider identification, further analysis and corrective action plan up to and including termination if necessary.	$25,000 if a provider fails 3 standard deviations from the mean for 3 consecutive reporting periods without corrective action by the Contractor.

28. Delete Section B.2 in its entirety and replace with the following:

B.2. Term Extension. TENNCARE reserves the right to extend this Contract, in increments of one (1) year each, for an additional two (2) years, provided that TENNCARE notified CONTRACTOR in writing of its intention to do so at least ninety (90) days prior to the Contract expiration date. The extension will be based on the ability of the CONTRACTOR and TENNCARE to negotiate a risk-based payment methodology using utilization data collected during the initial contract term. The ability to move to a risk based contract is based on the assumption that both the provider network and utilization will have been increased and stabilized during the initial contract term and, therefore, a suitable capitation figure can be determined. Based on the utilization data collected during the first eighteen (18) months of this Contract, an independent actuary will establish a monthly capitation rate to be paid per enrollee. If the State and CONTRACTOR cannot reach an agreement on the recommended capitation rate at least (90) days before the termination date of the Contract, the services will be rebid. If the extension of the Contract necessitates additional funding beyond that which was included in the original Contract, the increase in TENNCARE'S maximum liability will also be effected through an amendment to the Contract and shall be based upon rates negotiated with the CONTRACTOR for the extension period. Extension of the Contract is also contingent upon continuous approval of the TENNCARE 1115 waiver by the Centers for Medicare and Medicaid Services (formerly HCFA) during these time periods. Renegotiations may be made for good cause, only at the end of the contract period and for modification(s) during the contract period, if circumstances warrant, at the discretion of the State.

29. Delete D.9 in its entirety and replace with the following:

D.9. Monitoring. The Contractor's activities conducted and records maintained pursuant to this Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.

30. Add the following to D.15:

D.15.p. Title IX of the Education Amendments of 1972 (regarding education programs and activities)

D.15.q. The Rehabilitation Act of 1973

D.15.r. The Balanced Budget Act of 1997 Section 422.208 and 422.210

D.15.s. EEO Provisions

D.15.t. Copeland Anti-Kickback Act

D.15.u. Davis-Bacon Act

D.15.v. Contract Work Hours and Safety Standards

D.15.w. Rights to Inventions Made Under a Contract or Agreement

D.15.x. Byrd Anti-Lobbying Amendment

D.15.y. Debarment and Suspension

31. Delete E.5.a. in its entirety and replace with the following:

E.5.a. CONTRACTOR Breach— In event of a Breach by CONTRACTOR, the state shall have available the following remedies as described further herein. Before imposing any sanction against the CONTRACTOR other than termination of the contract, the State shall provide the CONTRACTOR entity with notice and such other due process protections as the State may provide, except that a State may not provide the CONTRACTOR with a predetermination hearing before the appointment of temporary management.

32. Insert the following as E.7 and renumber the remainder of Section E accordingly.

E.7. Solvency. The CONTRACTOR must provide assurances that Medicaid enrollees will not be liable for the CONTRACTOR's debt if the DBM becomes insolvent.. The CONTRACTOR must cover the continuation of services to enrollees for the duration of the period for which payment has been made.

33. Delete E.18 in its entirety and replace with the following:

E.18. Confidentiality of Records. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information in accordance with the provisions of applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. Such confidential information shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards.

The Contractor's obligations under this section do not apply to information in the public domain; entering the public domain but not from a breach by the Contractor of this Contract; previously possessed by the Contractor without written obligations to the State to protect it; acquired by the Contractor without written restrictions against disclosure from a third party which, to the Contractor's knowledge, is free to disclose the information; independently developed by the Contractor without the use of the State's information; or, disclosed by the State to others without restrictions against disclosure. Nothing in this paragraph shall permit Contractor to disclose any information that is confidential under federal or state law or regulations, regardless of whether it has been disclosed or made available to the Contractor due to intentional or negligent actions or inactions of agents of the State or third parties.

It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Contract.

34. Add the following to Section E, Special Terms and Conditions:

E. 30. HIPAA Compliance. Contractor warrants to the State that it is familiar with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this contract. Contractor warrants that it will cooperate with the State in the course of performance of the contract so that both parties will be in compliance with HIPAA, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations. Contractor will sign any documents that are reasonably necessary to keep the State and Contractor in compliance with HIPAA, including but not limited to business associate agreements.

E.31. Fraud and Abuse

Pursuant to Executive Order 47 and 42 CFR § 1007, the Tennessee Bureau of Investigation Medicaid Fraud Control Unit (TBI MFCU) is the state agency responsible for the investigation of provider fraud and abuse in the State Medicaid program (TennCare).

The TennCare Program Integrity Unit is responsible for assisting TBI MFCU with provider cases and has the primary responsibility to investigate TennCare enrollee fraud and abuse.

The Contractor shall immediately report to the TBI MFCU any known or suspected fraud and/or abuse, including, but not limited to, the false or fraudulent filings of claims and/or the acceptance or failure to return monies allowed or paid on claims known to be false or fraudulent. The Contractor shall not investigate or resolve the suspicion, knowledge or action without informing the TBI MFCU, and shall cooperate fully in any investigation by the TBI MFCU or subsequent legal action that may result from such an investigation. The Contractor and health care providers, whether participating or non-participating providers, shall, upon request and as required by this CRA or state and/or federal law, make available to the TBI MFCU any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are expended. In addition, the TBI MFCU shall, as required by this CRA or state and/or federal law, be allowed access to the place of business and to all TennCare records of any Contractor or health care provider, whether participating or non-participating, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the TBI MFCU.

The Contractor shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, the provider must comply with Section 1-5 of this CRA.

The Contractor shall report TennCare enrollee fraud and abuse to the TennCare Program Integrity Unit. The Contractor may be asked to help and assist in investigations by providing requested information and access to records. The Contractor and health care providers, whether participating or non-participating providers, shall, upon request and as required by this CRA or state and/or federal law, make available any and all supporting documentation/records relating to delivery of items or services for which TennCare monies are expended. Shall the need arise, the TennCare Program Integrity Unit shall be allowed access to the place of business and to all TennCare records of any TennCare Contractor or health care provider, whether participating or non-participating, during normal business hours, as required by this CRA or state and/or federal law.

Nothing herein shall require the CONTRACTOR to assure non-participating providers are compliant with TENNCARE contracts or state and/or federal law.

E.31.a. Prevention/Detection of Provider Fraud and Abuse

The CONTRACTOR shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential fraud and abuse activities.

E.31.b. Fraud and Abuse Compliance Plan

E.31.b.(1) The CONTRACTOR shall have a written Fraud and Abuse compliance plan. A paper and electronic copy of the plan shall be provided to the TennCare Program Integrity Unit. The CONTRACTOR's specific internal controls and polices and procedures shall be described in a comprehensive written plan and be maintained on file with the CONTRACTOR for review and approval by the TennCare Program Integrity Unit within ninety (90) days of the effective date of this Agreement. The TennCare Program Integrity Unit shall provide notice of approval, denial, or modification to the CONTRACTOR within thirty (30) days of review. The CONTRACTOR shall make any requested updates or modifications available for review to TENNCARE and/or the TennCare Program Integrity Unit as requested by TENNCARE and/or the TennCare Program Integrity Unit within thirty (30) days of a request. The State shall not transfer their law enforcement functions to the CONTRACTOR. At a minimum the written plan shall:

i. Ensure that all officers, directors, managers and employees know and understand the provisions of the CONTRACTOR's fraud and abuse compliance plan;

ii. Contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract:

iii. Include a description of the specific controls in place for prevention and detection of potential or suspected abuse and fraud, such as:

(a) Claims edits;
(b) Post-processing review of claims;
(c) Provider profiling and credentialing;
(d) Prior authorization;
(e) Utilization management;
(f) Relevant subcontractor and provider agreement provisions;
(g) Written provider and enrollee material regarding fraud and abuse referrals.

iv. Contain provisions for the confidential reporting of plan violations to the designated person as described in item 3 below;

v. Contain provisions for the investigation and follow-up of any compliance plan reports;

vi. Ensure that the identities of individuals reporting violations of the plan are protected;

vii. Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;

viii. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU and that enrollee fraud and abuse be reported to the TennCare Program Integrity Unit;

ix. Ensure that no individual who reports plan violations or suspected fraud and abuse is retaliated against.

E.31.b(2) The CONTRACTOR shall comply with the applicable requirements of the Model Compliance Plan for HMOs when the final model plan is issued by the U.S. Department of Health and Human Services, the Office of Inspector General (OIG).

E.31.b(3) The CONTRACTOR shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.

E.31.b(4) The CONTRACTOR shall submit an annual report to the TennCare Program Integrity Unit that includes summary results of fraud and abuse tests performed as required by 1-5.b.1.iii. and detailed in the CONTRACTOR's Fraud and Abuse compliance plan. The report should cover results for the year ending June 30 and be submitted by September 30 each year. This information in this report shall be provided in accordance with and in a format as described in the CONTRACTOR's approved compliance plan.

35. Delete the first paragraph in Attachment I, Dental and Oral Health Services Benefits, in its entirety and replace with the following:

Covered services for TennCare eligible enrollees under 21 years of age. Covered services consist of preventive, diagnostic and treatment services as follows:

36. Add the following to Attachment IV:

II.A.17. Shall include other information on requirements for accessing services to which they are entitled under the contract including factors such as physical access and non-English languages spoken as required in the Balanced Budge Act of 1997, Section 438.10(f)3.

37. Delete IV.E in Attachment IV in its entirety and replace with the following:

IV.E Direct solicitation of potential enrollees; and

38. Add the following language to Attachment IV, Section IV:

I.V.G. Seeking to influence enrollment in conjunction with the sale or offering of any private insurance.

39. Add the following language to Attachment VI, SECTION 1, STANDARD 1:

G. The QMP guidelines must be disseminated to all affected providers and, upon request, to enrollees and potential enrollees.

40. Delete Attachment IV, SECTION 1, STANDARD IX, Letter D in its entirety and replace with the following:

D. Scope – The Contractor shall identify those practitioners to be credentialed that fall under its scope of authority and action. Practitioners to be credentialed shall include, at a minimum, all dentists included in the Contractor's literature for members, as an indication of those practitioners whose service to member is contracted or anticipated. The Contractor shall submit a plan to the TennCare Bureau outlining the process which it shall employ to ensure appropriate and timely credentialing of all providers participating in the dental plan. In all contracts with health care professionals, the

Contractor must comply with the requirements specified in the Balanced Budget Act of 1997, Section 438.214.

41. Delete Attachment IV, S TANDARD X, A.6 in its entirety and replace with the following A.6, A.7, A.8, and A.9:

A.6. to be guaranteed the right to request and receive a copy of his or her dental records, and to request that they be amended or corrected as specified in 45 CFR part 164;

A.7. to be guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

A.8. to be free to exercise his or her rights, and that that exercise of those rights does not adversely affect the way the DBM and it's providers or the State agency treat the enrollee.

A.9. to be guaranteed the right to receive information on available treatment options and alternatives presented in a manner appropriate to the enrollee's condition and ability to understand.

42. Delete Numbers 17, 18 and 19 of Attachment VII, Definitions, in their entirety and replace with the following:

17. Emergency Services – means covered inpatient and outpatient services that are: furnished by a provider that is qualified to furnish these services under this title and that are needed to evaluate or stabilize an emergency medical condition.

18. Emergency Medical Condition – means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy, serious impairments to bodily functions, or serious dysfunction of any bodily organ or part.

19. Enrollee - A Medicaid recipient or Medicaid Waiver recipient who is currently enrolled in an MCO, PIHP, PAHP or PCCM in a given managed care program.

43. Add the following new definitions to Attachment VII, Definitions, in alphabetical order and renumber accordingly.

Cultural Competence - the level of knowledge-based skills required to provide effective clinical care to patients of particular ethnic or racial groups.

Potential Enrollee – A Medicaid recipient or Medicaid Waiver recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, and PCCM.

DORAL DENTAL OF TENNESSEE, LLC:

RONALD A. BRUMMEYER, PRESIDEENT **Date**

DEPARTMENT OF FINANCE AND ADMINISTRATION

BUREAU OF TENNCARE

M. D. Goetz, Jr., Commissioner **Date**

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz, Jr., Commissioner **Date**

COMPTROLLER OF THE TREASURY:

John G. Morgan, Comptroller of the Treasury **Date**